**Client ID:**

**ADULT REFERRAL FORM – External**

Email to: [referral@laurelplace.com.au](mailto:referral@laurelplace.com.au)

**Date of Referral:**

**CLIENT DETAILS:**

|  |  |
| --- | --- |
| **Name of Client:** | **DOB:** |
| **Preferred Name:** | |
| **Address:** | |
| **Home:** | **Mobile:** |
| **Email:** | **Consent to email: YES**  **NO** |
| **Gender: Female**  **Male**  **Non-Binary**  **Different Term**        **Prefer not to state** | |
| **Does client identify as a First Nations person?** **YES**  **NO** | |
| **Indigenous Status:** Aboriginal  Torres Strait Islander  Not stated | |
| **Does Client identify as Culturally and Linguistically Diverse?** YES  NO | |
| **Identified cultural background:** | |
| **Interpreter required: NO**  **YES** **Language:**  **Does the client experience a disability?** NO YES | |

**CONSENT**

**Is the client aware a referral has been made to Laurel Place? YES**  **NO**

**Has the client consented to be contacted by Laurel Place? YES**  **NO**

**Safe to leave voicemail messages: YES**  **NO**  **Safe to SMS: YES**  **NO**

**REFERRAL SOURCE**

**Referring Agency & Contact Person:**

|  |  |
| --- | --- |
| **Phone No:** | **Email:** |

**\*Reason for Referral:**

**RECENCY OF ASSAULT**

within 7 days, within 3 months,  > 3months,  historical (> 12 months),  childhood

Not stated

**Recency of disclosure:**

**Other recent trauma event/stressor:**

**CURRENT SAFETY/RISK FACTORS IDENTIFIED (If yes, please provide further information):**

Suicidal ideation No  Yes

*\*Please note –Laurel Place is not a crisis service. If immediate risk is identified, please refer to emergency or acute services\*.*

Self-harm No  Yes

Harm to others No  Yes

Child safety No  Yes

Domestic Violence No  Yes

Substance Use No  Yes

Eating Issues/Disorder No  Yes

Contact with perpetrator No  Yes

Has the assault been reported to police? No  Yes

**CURRENT SUPPORTS**:

**OTHER RELEVANT INFORMATION**: